

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT**FACILITIES DEVELOPMENT DIVISION ~**1600 9th Street, Room 420 ~ Sacramento, California 958141831 9th Street ~ Sacramento, California 95814

311 South Spring Street, Suite 1001, Los Angeles, CA 90013

Phone (916) 654-3362 FAX (916) 654-2973

Phone (916) 324-9090 FAX (916) 324-9145 North and Central Region

Phone (213) 897-0166 FAX (213) 897-0168

www.oshpd.state.ca.us/fdd

**Plan Review Application Under Incremental Project (Increment)**

A	Name of Facility:				OSHPD #:					
	Address - Street:		Phone:							
			FAX #:		Increment #:					
	City:		County:				Zip:			
	Administrator:		Phone:		Facility I.D. #:					
			FAX #:							
		E-mail:		OFFICE USE ONLY SUBMITTAL <input type="checkbox"/> Field Review <input type="checkbox"/> Revised Final <input type="checkbox"/> Examination <input type="checkbox"/> OTC <input type="checkbox"/> Final <input type="checkbox"/> Expedite						
Scope of Project (45 characters max):		Applicant Job #:								
B	Description of Project:				DISTRIBUTION <input type="checkbox"/> OSHPD <input type="checkbox"/> Project File <input type="checkbox"/> Rad. Health <input type="checkbox"/> L & C <input type="checkbox"/> _____					
C	Application for Plan Review made by (Name typed):				OSHPD RECEIPT STAMP					
	Signature:		Date:							
	Title:		Phone #:							
	Address:		FAX #:							
	City:		State:				Zip:		E-mail:	
	Who is to be known as: <input type="checkbox"/> Legal Owner/Administrator									
	<input type="checkbox"/> Agent for the Legal Owner/Administrator (Authorization must be attached)									
D	Enclosed with this application are the following documents:									
	_____ Plans									
	_____ Specifications									
	_____ Structural Calculations									
	_____ Equipment Anchorage Calculations									
	_____ Design Program (Optional)									
	_____ Testing, Inspection and Observation Program (TIO)									
	_____ Verification of conformance to Local Codes (for New Facilities and Additions)									

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E	Name of Facility (from front page)		OSHDP #
F	Plans and Specifications prepared by the following: Check discipline in general responsible charge of project		
	Architect – Firm <input type="checkbox"/>		
	Individual Responsible:	Lic. #:	E-mail:
	Alternate:	Lic. #:	E-mail:
	Address:		Phone #:
	City:	State:	Zip: FAX #:
	Structural Engineer – Firm <input type="checkbox"/>		
	Individual Responsible:	Lic. #:	E-mail:
	Alternate:	Lic. #:	E-mail:
	Address:		Phone #:
	City:	State:	Zip: FAX #:
	Mechanical Engineer – Firm <input type="checkbox"/>		
	Individual Responsible:	Lic. #:	E-mail:
	Alternate:	Lic. #:	E-mail:
	Address:		Phone #:
	City:	State:	Zip: FAX #:
	Electrical Engineer – Firm <input type="checkbox"/>		
	Individual Responsible:	Lic. #:	E-mail:
	Alternate:	Lic. #:	E-mail:
	Address:		Phone #:
	City:	State:	Zip: FAX #:
	Geotechnical Report – Firm <input type="checkbox"/>		
	Individual Responsible:	Lic. #:	E-mail:
	Alternate:	Lic. #:	E-mail:
	Address:		Phone #:
	City:	State:	Zip: FAX #:

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INSTRUCTIONS FOR Plan Review Application Under Incremental Project (Increment) (OSH-FD-128)

Do not write in Office Use Only area on this application.

Note: If licensure by the California Department of Health Services is not required by your facility, review by OSHPD is not required and the application is not required. Your application and plans should be submitted to local jurisdictions.

- A Enter facility name, street address, city, county, and zip code (five or nine digit zip code as applicable). Enter name of administrator, phone number, fax number, and e-mail address.

Scope of project - enter a brief (45 characters or less) description statement of the work to be performed. Applicant jobs number - if the facility or architect has a numbering system for projects, enter that project number.

- B Description of Project - Describe the work to be performed. Where appropriate, include square footage and quantities.

- C This application for plan review is to be signed and dated by the legal owner or administrator of the facility, or agent. If signed by the agent of the legal owner or administrator, the authorization shall be attached to this application. Indicate in the appropriate boxes the name, signature, date, title, address, phone number, fax number, city, state, zip code, and e-mail address of the applicant.

- D Indicate the number of documents enclosed.

- Plans and Specifications - Submit one (1) set of plans and specifications for projects involving the structural frame of a health facility.
- Submit one (1) set of plans and specifications for nonstructural health facility projects or for one story, type five skilled nursing facilities.
- Submit copies of structural calculations and equipment anchorage calculations.
- The applicant may submit a copy of the design program if desired.
- Testing, Inspection, and Observation Program (TIO)
- If verification of conformance to local is required, indicate that these are being included with the application.
- A space is provided for additional information or documents being enclosed with the application.

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- E Enter the name of the facility from Section A on Page 1.
- F Provide information for those disciplines which are involved in this project. Check the box for the discipline, which is in general responsible charge of this project. For each discipline, provide the name of the individual in responsible charge of the project, e-mail address, his/her license number, an alternate person to contact, e-mail, his/her license number, the address, phone and fax number, city, state, and zip code.